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Testimony to the Senate Committee on Agriculture, Nutrition & Forestry
Examination of Federal Food Safety Oversight in the Wake of Peanut Products Recall

February 5, 2008
Washington, DC

Thank you Senator Leahy and Chairman Harkin, and the rest of the Committee for the opportunity to appear before you today and share the story of my son Christopher and our experience with the recent *Salmonella* outbreak and the peanut recall that followed.

On Thanksgiving night, November 25, 2008, my perfectly healthy and robust seven-year-old son, Christopher, spiked a very high fever, started throwing up, and having diarrhea. His father and I suspected it was the flu, as did our Pediatrician, so we limited his food and made sure he got plenty of fluids. Two days later Christopher's health deteriorated dramatically, he was severely ill and in tremendous pain; a pain that no child should ever have to experience and as a mother one that I will never forget as I sat by his bedside. We immediately called our Pediatrician who instructed us to bring him to the hospital.

We asked ourselves how in the world could a seemingly perfectly healthy child get so sick in such a short period? However, once the lab results finally came back and he was diagnosed with *Salmonella,* the picture became clearer. Thankfully, after days of antibiotics, anti-fungus drugs, and no food or drink, his wrecked body finally stabilized to a point where he could come home. This, after six days and nights filled with fear and unanswered questions.

Senators I could spend all day telling you about Christopher's terrible experience and the questions that still linger about the long-term ramifications for his health, but I would rather use my limited time here today to help make change and progress for the future. Some excellent ideas have already been proposed for improving our food safety system and I would like to add a few of my own, while highlighting some of the mistakes I witnessed firsthand during Christopher's ordeal. I must start by praising the first line of defenders in the fight against foodborne illness. Senators it is my experience that this is the only part of the foodborne illness safety system that works well.

<u>Technology and Information</u>
First, and foremost I believe that technology is the key to making our foodborne illness response work better and in a cohesive manner. I believe there needs to be a national online foodborne illness database/registry that can be used by victims as soon as a *Salmonella* or other foodborne illness has been diagnosed. Such a tool would allow patients or their caregivers to log on to the registry and fill out a questionnaire about food eaten in the seven days prior to illness onset**.** This can be done while the patient is still in the hospital or in the Doctor's office. By doing this step immediately, the information is still fresh in the victim's mind rather than on the phone for a two and a half hour interview over a week after the initial diagnosis.

In this age of technology, text messages, and instant messaging; I do not understand why victims could not be given access to a secure website and chat-room to allow them to talk to one another and possibly solve the question of which food poisoned them. In Christopher's case, he is a very picky eater. I am chagrinned to say that my son mostly eats cheese, milk, yogurt, peanut butter, and snacks like chips, peanuts or crackers. Had I had an opportunity to talk to other mothers whose children were sick, and compare what they had eaten I have no doubt we could have cracked this case back in early December.

In addition to using technology to get information from victims, I feel that it can be used better for sharing information with victims and the public. In my opinion, the agencies involved with any outbreak should never underestimate how much victims and the public crave information. I was kept in the dark for way too long throughout this process, at one point having to insist that I be told what specific kind of *Salmonella* Christopher had, even though the health worker I was speaking to said that "I didn't need to know." The victims must be kept in the loop with real time information and there needs to be a way to reach all the victims by phone. I believe that a computerized phone message to victims could easily be established for disseminating information -- after all how many people in this room got text messages from the president during the inauguration weekend?

In this case, as soon as there was the slightest possibility that crackers and other foods were the culprit, we should have received a message telling us to remove any peanut butter crackers from our house. Thankfully, a coworker of mine read that tainted Crackers possibly contained Salmonella. Then it all made sense, Christopher had eaten a package of cheese and peanut butter crackers but no one else in our family had. This is where our case hit another roadblock, when I called the CDC about the crackers, which we still had in our pantry, no one would take my call. Thankfully, when I called the FDA, I found someone willing to listen, unfortunately it was the weekend and that Monday was a holiday so no one could pick up the crackers until Tuesday. However, in a shocking twist the woman I spoke with at the FDA then also wanted to give me a questionnaire about all the foods Christopher had eaten, all the same information I had already given the CDC. I do not understand why the various agencies working on this outbreak did not already have our information. Technology must be used to share information between all the teams and lines of defense working on an outbreak.

In addition to notifying victims, the public needs to be kept informed as well, perhaps with an alert system similar to those for storm warnings. This system could also be utilized to update the public when it is safe to eat a certain food again. Right now it has is a guessing game for the public – and sometimes just a game of Russian roulette.

<u>Identification</u>

Next, I believe there should be a unified procedure for the identification of all Salmonella cases. If one state does this best, then they should share their procedures and best practices with the rest of the country for the fastest turn around possible. Once identification is made and the data entered into the registry, the correlations can be made to determine if there is a pattern developing. If there is, then there is already a litany of information regarding foods eaten, already provided by the victims so swift action can be taken.

National Team

After our experience, I believe that there should be one team involved at the National level in charge of the follow up. Such a national team could again use technology and the registry/database for all their information dissemination to all lines of defense and data gathering. It is crucial that four lines of defense have access to the information on the database, this includes the local Doctors and hospitals, the State Health Departments, the CDC, and finally the FDA. With one team involved in tracking and organizing the investigation, if any sort of clusters or patterns are identified by that team, this information can be shared to all parties through the registry database.

As the system is now, Christopher's doctors had to ask around on their own if other local pediatricians had patients with similar symptoms. Had there been a national database, they would have seen that on the date that Christopher was diagnosed, that there was already a cluster of Salmonella elsewhere in the U.S. They could have then seen if there were any other cases in Vermont. This information is important for the first lines of defense to have – even if does not effect their specific region of care. If we were to have a Bioterrorist act through food, this data would be invaluable information to all lines of defense.

Personal Responsibility

Finally, I believe there needs to be personal responsibility in manufacturing and growing foods for consumption by the public. The owners of companies must be personally responsible for the safety of the foods they sell. Inspection records should online and made available to the general public, owners should have to log-on to a database at regular intervals, depending on the amount of products produced, and personally attest to the safety of their food.

Manufacturers must take responsibility for all items that go into their products, and therefore if they are purchasing supplies and ingredients from other companies, they need to attest and be equally responsible for that ingredient as well. If their supplier is listed on a public database and personally attesting for the safety of their product then their liability for that supplier is lowered if their supplier is meeting all required standards. In this particular case, there has rightfully been a lot of blame placed on the plant where the contaminated product originated, however I believe that large suppliers of food products, should have a clear process to verify that their suppliers are meeting national standards. Clearly, that did not happen in this case, and now the government must ensure this will never happen again.

Thank you again to the committee for holding this hearing today. I would like to close by thanking the Staff at the Children's Hospital of Vermont for treating Christopher so promptly. Our family is so thankful that he received the best care in the world and lucky for us he was a big boy to begin with. I shudder to think of the outcome had he been an underweight or sickly child to begin with and my heart goes out to all of the other victims and their families.

Again, thank you and I welcome any questions you may have.